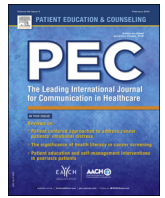




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Randomized trial of a question prompt list to increase patient active participation during interactions with black patients and their oncologists

Susan Eggly^{a,*}, Lauren M. Hamel^a, Tanina S. Foster^a, Terrance L. Albrecht^a, Robert Chapman^b, Felicity W.K. Harper^a, Hayley Thompson^a, Jennifer J. Griggs^c, Richard Gonzalez^c, Lisa Berry-Bobovski^a, Rifky Tkatch^a, Michael Simon^a, Anthony Shields^a, Shirish Gadgeel^a, Randa Loutfi^b, Haythem Ali^b, Ira Wollner^b, Louis A. Penner^a

^a Wayne State University/Karmanos Cancer Institute, 4100 John R, Detroit, MI, USA

^b Henry Ford Hospital/Josephine Ford Cancer Institute, Detroit, MI, USA

^c University of Michigan, Ann Arbor, MI, USA

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ABSTRACT

Objective: Communication during racially-discordant interactions is often of poor quality and may contribute to racial treatment disparities. We evaluated an intervention designed to increase patient active participation and other communication-related outcomes during interactions between Black patients and non-Black oncologists.

Methods: Participants were 18 non-Black medical oncologists and 114 Black patients at two cancer hospitals in Detroit, Michigan, USA. Before a clinic visit to discuss treatment, patients were randomly assigned to usual care or to one of two question prompt list (QPL) formats: booklet (QPL-Only), or booklet and communication coach (QPL-plus-Coach). Patient-oncologist interactions were video recorded. Patients reported perceptions of the intervention, oncologist communication, role in treatment decisions, and trust in the oncologist. Observers assessed interaction length, patient active participation, and oncologist communication.

Results: The intervention was viewed positively and did not increase interaction length. The QPL-only format increased patient active participation; the QPL-plus-Coach format decreased patient perceptions of oncologist communication. No other significant effects were found.

Conclusion: This QPL booklet is acceptable and increases patient active participation in racially-discordant oncology interactions. Future research should investigate whether adding physician-focused interventions might improve other outcomes.

Practice implications: This QPL booklet is acceptable and can improve patient active participation in racially-discordant oncology interactions.

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1. Introduction

Black-White treatment disparities exist across many cancers [1–6]. Multiple factors contribute to these disparities [7,8], but one likely contributor is the quality of patient-physician communication during clinical interactions [9–12]. Communication during interactions with Black patients and non-Black physicians is often of poorer quality than during interactions with White patients. For

example, patients in racially-discordant interactions tend to ask fewer questions [13] and participate less in decision making [14]; while physicians tend to be less patient-centered [15,16]; more verbally dominant [16]; more contentious [17]; exhibit fewer positive, rapport-building nonverbal communication behaviors [18]; engage in fewer relationship-building attempts [19]; and provide less information [20,21]. This is extremely important because, due to the very small number of Black oncologists in the United States, most interactions for Black cancer patients are racially-discordant [22].

* Corresponding author.

E-mail address: egglys@karmanos.org (S. Eggly).

One well-documented communication-related disparity is the amount of information Black patients and their physicians exchange during clinical interactions. Black patients often ask fewer questions than White patients and are less likely to bring companions who may ask questions on their behalf [13]; and physicians provide less information [19–21,23]. Also, interactions with Black patients are often shorter [21,24], possibly indicating less information exchange and lower quality communication and care [24–26]. Thus, interventions are needed to improve information exchange and other aspects of communication during these interactions. One way to do this is by increasing patient active participation. Patient active participation plays an important role in short-, intermediate-, and long-term outcomes [27,28] due to its association with the amount of information physicians provide [29–31], treatments physicians recommend [11], topics patients and physicians discuss [32], and patient psychosocial and physical health outcomes [33,34].

We tested the acceptability and effectiveness of an intervention designed to increase patient active participation in racially-discordant clinical interactions. The intervention was a question prompt list (QPL), a list of questions related to a medical condition that patients might want to ask their physician during clinic visits. QPLs are designed as a simple, inexpensive way to help patients gain more information about their diagnosis and treatment and enhance patient-provider communication [35–38]. Although QPLs have been used successfully in several oncology settings [31,39,40], they have not, as far as we know, been evaluated in the context of racially-discordant oncology interactions.

The QPL for this study was developed in collaboration with Black patients and family members, community members, and oncologists [41]. We provided it to patients in one of two formats. In the first (“QPL-Only”), patients received the QPL as a booklet. In

the second (“QPL-plus-Coach”), patients received the QPL booklet and the assistance of a communication coach, whose role was to help patients consider which questions they might ask during the clinical interaction. We tested two QPL formats because of concerns that the booklet alone might have limited benefit for patients with lower levels of education. Additionally, we believed that patients might be more likely to benefit from the QPL if it was presented to them by a coach who was also Black, given research suggesting that Black patients are often less trusting of physicians and medical institutions than White patients [42–45].

This study extends prior research on the acceptability and effectiveness of QPLs in several ways. First, we evaluated acceptability by assessing patient perceptions of both formats of the QPL. Based on prior research and the fact that the QPL was developed collaboratively with stakeholders [41], we expected favorable perceptions. We also assessed acceptability by determining the effect of the intervention on interaction length because significantly increasing interaction length might reduce feasibility in clinical settings. Findings from prior studies evaluating the effect of QPLs on interaction length have been mixed, with most suggesting no significant effects [35,37,86]. Thus, we expected neither format to significantly increase interaction length.

Second, we investigated direct effects of the QPL by evaluating whether patients who received it in either format would participate more actively during interactions than patients who did not. We defined active participation to include communication behaviors such as asking questions, making assertions, and stating concerns [46,47]. Based on prior research [35,38], we expected patients who received the QPL in either format to participate more actively than patients who did not, and patients who received the QPL-plus-Coach to participate more actively than patients who received the QPL-Only.

Table 1
 Socio-demographic characteristics of participants.

Patients (n = 114)	Usual Care (n = 40)	QPL Only (n = 40)	QPL + Coach (n = 34)	Total (N = 114)
Age	M = 57.35 (SD = 11.07)	M = 60.82 (SD = 9.32)	M = 58.44 (SD = 10.56)	M = 58.89 (SD = 10.35)
Sex				
Female	36 (90%)	37 (92.5%)	31 (91.2%)	104 (91.2%)
Male	3 (7.5%)	3 (7.5%)	3 (8.8%)	9 (7.9%)
Education				
<High School	11 (27.5%)	6 (15.0%)	9 (26.5%)	26 (22.8%)
Graduated High School	3 (7.5%)	6 (15.0%)	5 (14.7%)	14 (12.3%)
Some College	14 (35.0%)	15 (37.5%)	9 (26.5%)	38 (33.3%)
Graduated College	9 (22.5%)	7 (17.5%)	5 (14.7%)	21 (18.4%)
Post-graduate degree	3 (7.5%)	6 (15.0%)	6 (17.6%)	15 (13.2%)
Annual Household Income				
0–\$19,999	18 (45.0%)	14 (35.0%)	14 (41.2%)	46 (40.4%)
\$20,000–\$39,999	12 (30.0%)	13 (32.5%)	7 (20.6%)	32 (28.1%)
\$40,000–\$59,999	3 (7.5%)	4 (10.0%)	3 (8.8%)	10 (8.8%)
\$60,000–\$79,999	3 (7.5%)	3 (7.5%)	4 (11.7%)	10 (8.8%)
>\$80,000	2 (5.0%)	4 (10.0%)	3 (8.8%)	9 (7.9%)
Primary Tumor Site				
Breast	32 (80.0%)	34 (85.0%)	28 (82.4%)	94 (82.4%)
Colorectal	3 (7.5%)	3 (7.5%)	2 (5.9%)	8 (7.0%)
Lung	5 (12.5%)	3 (7.5%)	4 (11.8%)	12 (10.5%)
Oncologists (n = 18)				Across Arms
Age				M = 46.76 (SD = 10.60)
Male				10 (56%)
Race/Ethnicity				
Caucasian or White				10 (56%)
Asian or Pacific Islander				4 (22%)
Arab-American/Mideastern				4 (22%)
Position				
Attending				15 (83.3%)
Fellow				3 (16.7%)

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